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NO. 193 [redacted]

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM [redacted] 1969

WILLIAM A. THORNE, Receiver,
Atlas Lumber & Door Co.

vs.

AETNA LIFE INSURANCE COMPANY

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

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William A. Thorne, Receiver, Atlas Lumber & Door Co., prays that a Writ of Certiorari issue to review the judgment of the United States Court of Appeals for the Seventh Circuit entered in the above cause on February 24, 1969.

OPINIONS BELOW

The opinion of the United States District Court was reported in 286 F.Supp. 620. Judgment was rendered on Findings of

Fact and Conclusions of Law on April 22, 1968. The opinion of the Court of Appeals rendered on February 24, 1969, is published in 407 F.2d 809. The denial of the Petition for Rehearing is not published, but rehearing was denied on March 19, 1969. The opinion of the District Judge and the opinion of the Court of Appeals are reproduced in Appendix A.

JURISDICTION

1. Judgment was rendered on the Findings of Fact and Conclusions of Law on April 22, 1968.

2. On February 24, 1969, the Court of Appeals rendered its decision, and on March 19, 1969, the Court of Appeals denied the Petition for Rehearing.

3. Jurisdiction of this Court is invoked under 28 U.S.C. 1254, Sec. 1.

QUESTIONS PRESENTED FOR REVIEW

The first question presented for review is whether or not under Indiana law

an insurance company could accept payment of premiums in advance and issue a Binding Receipt and subsequent thereto, on the death of the insured, deny liability, notwithstanding that it had issued a Binding Receipt containing conditions subsequent which conditions were never invoked by the insurance company.

The second question presented is whether or not under Indiana law an insurance company with complete knowledge of all the facts waived its requirements for coverage.

STATUTES INVOLVED

There are no constitutional provisions, treaties, statutes, ordinances or regulations which the case involves.

CONCISE STATEMENT OF THE CASE

Federal jurisdiction was invoked because of the diversity of citizenship of the parties under 18 U.S.C.A. 1332, which was uncontested. The plaintiff was a citizen

of the State of Indiana, and the defendant of the State of Connecticut. The amount in controversy exceeded the sum of Ten Thousand ($10,000.00) Dollars, which facts are admitted.

The factual situation was that on December 10, 1964, one Robert Glenn Reynolds signed an application for a life insurance policy with the defendant insurance company in the amount of One Hundred Thousand ($100,000.00) Dollars, with the Atlas Lumber & Door Co., Inc. the beneficiary. The plaintiff here, William A. Thorne, is Receiver of that company. Included with the application was an aviation supplement covering the life of Reynolds in the event he died as the result of an airplane crash. After the application was filled out and signed, a check was paid by the corporation to the insurance company, being the first month's premium. This check was cashed on December 17, 1964. The agent then gave

Reynolds a form entitled "Binding Receipt" for payment to apply on first premium. Reynolds left South Bend by plane on December 23, 1964, without taking medical examination and his plane crashed in Florida, causing his death on January 3, 1965. The application was never rejected in the lifetime of the insured. On January 8, 1965, the insurance company denied liability on the basis that no policy had issued and made a tender of the premium paid. Prior to that, on September 30, 1964, Reynolds had applied for a Thirty-Three Thousand ($33,000.00) Dollars decreasing term policy and had paid a binding payment on that and a Binding Receipt had issued as well, and this application was never rejected. He took a physical examination but was requested to take another one, which he never took. With knowledge of these facts, the insurance company then took the subsequent application on December 10, 1964.

BASIS FOR JURISDICTION OF THIS COURT

This Petition is filed under Rule 19 (1,b).

A. The Court of Appeals has decided an important state question in a way in conflict with applicable state law in each of the following respects:

1. The case of Western & Southern Life Ins. Co. v. Vale (1937), 213 Ind. 601; 12 N.E.2d 350, holds that an interim insurance is created by a Binding Receipt and is effective as of the date of the Receipt, subject to the right of the company to reject it if upon reasonable grounds the applicant was not insurable on that date, and that it would be unconscionable to permit an insurance company issuing a Receipt and seeking a premium from applicant, part of which was to pay for protection under its policy from the date of the application to the date of acceptance, to say that it had not bound itself to give anything whatsoever

for that portion of the premium.

2. The Court rendered a decision in conflict with Western & Southern Life Ins. Co. v. Vale (1937), 213 Ind. 601; 12 N.E.2d 350, which held that a condition such as the one in the case at bar was a condition subsequent and not a condition precedent and, therefore, until the policy was rejected by the insurance company, there was insurance coverage.

B. The United States Court of Appeals departed from the accepted and usual course of judicial proceedings in that it failed to decide the question of whether or not the insurance company waived requirements by accepting the premiums with its previous knowledge of all the facts when it issued its Binding Receipt. As stated in the case of Western & Southern Life Ins. Co. v. Ross, Admr. (1930), 91 Ind.App. 552; 171 N.E. 212, when an insurance company collects premiums on a policy and at the time of collecting

the premiums it had knowledge that the insured was not in sound health, it thereby waived such conditions as to sound health and thereafter cannot avoid such policy, upon which question the Court of Appeals did not rule.

ARGUMENT

The Court decided this case contrary to Western & Southern Life Ins. Co. v. Vale (1937), 213 Ind. 601; 12 N.E.2d 350. The facts were found by the United States District Judge in the Court below and the District Court, in its opinion, said that one of the questions is whether or not the insurance company's satisfaction as to evidence of insurability is operative as a condition precedent. The Court said that this question should be answered in the negative. (Joint Appendix, p. 46) (Appendix A attached hereto) Notwithstanding this fact, the District Court went on to say that the determination by the insurance

company of insurability was required before a determination could be made. (Joint Appendix, p. 48) (Appendix A attached hereto)

This is strictly controvening the opinion of Western & Southern Life Ins. Co. v. Vale (1937), 213 Ind. 601; 12 N.E.2d 350, in which case the Indiana Supreme Court states that interim insurance is created by a Binding Receipt and is effective as of the date of receipt subject to the right of the company to reject it if, upon reasonable grounds, the applicant was not insurable on that date. In this case, there is no question the insurance was never rejected.

The importance of the case at bar is that it affects every applicant for insurance who may make a payment of premium in advance. An insurance company can, by this decision, take applicant's funds and then if something occurs adverse to the interests of the insurance company, it can then reject coverage on the ground that the

conditions which it laid down unilaterally can avoid issuance of the policy. This is strictly a method by which insurance companies can avoid liability while they retain the consideration of the funds. As stated by the Indiana Supreme Court in Vale:

> "It cannot be assumed that the applicant knowingly and intentionally paid his money to the company without any consideration, nor can it be assumed, in fairness to the company, that it intended to take the applicant's money without any consideration, and with the intention that he should not be insured upon any conditions for the period between the signing of the application and its acceptance and approval. Since no other reasonable construction is suggested, the agreement must be construed as intending that he be insured for the period, if reasonably insurable. This is undoubtedly what the applicant understood and believed he was agreeing to. It would be unconscionable to permit the company to assert that there was a meeting of the minds upon any other basis."

Western & Southern Life Ins. Co. v. Vale (1937), 213 Ind. 601; 12 N.E.2d 350, at 355.

This has been followed in the Federal Courts by Gaunt v. John Hancock Life Ins. Co.

(CCA 2), 160 F.2d 599, and also in other states as in Allen v. Metropolitan Life Ins. Co. (N.J. 1965), 208 A.2d 638, and Shannon v. Prudential Ins. Co. (N.J. 1966), 218 A.2d 880. Indiana has been stronger than most states in holding an insurance company, under circumstances as here, is under obligation to accept responsibility. The District Court completely overlooks the law of Indiana and has decided this case on entirely different grounds. The Court of Appeals never decided this question.

On the question of the conditions, such as in the case at bar, Vale again says that the Binding Receipt in this case, which Binding Receipt carried the words BINDING RECEIPT in large letters and the Conditions in very small letters, indicates to the extent that an insurance company can go in leaving the impression that an insured is covered. This is important to every person who has ever applied for insurance and should be clearly decided on the basis of

Indiana law.

The other question involved here is whether or not an insurance company having knowledge of all of the facts can waive its requirements as stated in the case of Western & Southern Life Ins. Co. v. Ross, Admr., 91 Ind.App. 552; 171 N.E. 212. In that case it is held that an insurance company collecting premiums on a policy at a time it had knowledge that the insured was not in sound health, thereby waived that condition as to sound health and thereafter cannot avoid the policy. The Court of Appeals did not decide this question although it was properly before it and we respectfully submit that the Court of Appeals departed from the accepted and usual course in judicial proceedings in failing to decide this question.

The Court of Appeals apparently decided this question only on the ground that fraud was not involved; however, the

Complaint was in a number of paragraphs and fraud was only one, which question was not discussed in the proceedings in the Circuit Court of Appeals. The appeal was based upon the fundamental doctrine of Western & Southern Life Ins. Co. v. Vale (1937), 213 Ind. 601; 12 N.E.2d 350, and Western & Southern Life Ins. Co. v. Ross, Admr., 91 Ind.App. 552; 171 N.E. 212.

CONCLUSION

We respectfully submit that the question involved here was improperly decided by the Circuit Court of Appeals and involved a substantial question of great importance to all applicants for insurance, and that the Petition for Writ of Certiorari should be granted.

Respectfully submitted,

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FINDINGS OF FACT AND CONCLUSIONS OF LAW.

I.

Findings of Fact.

1. The plaintiff, William A. Thorne, is the duly-qualified receiver of the Atlas Lumber and Door Company, Inc., and was at the time of the commencement of this action a citizen of the State of Indiana.

2. The defendant, Aetna Life Insurance Company, was at the time of the commencement of this action, a corporation incorporated under the laws of the State of Connecticut and had its principal place of business in that State.

3. The amount in controversy exceeds the sum of Ten Thousand ($10,000.00) Dollars, exclusive of interest and cost.

4. At all revelant times, Walter M. Knoop was agency supervisor for the South Bend agency of defendant company.

5. From November 17, 1964, until his death, Robert Glenn Reynolds, a resident of Elkhart, Indiana, was the president and principal stockholder of the Atlas Lumber and Door Company, Inc.

[431] 6. On December 10, 1964, in the presence of agent Knoop, Reynolds filled out and signed an application for a policy of life insurance with defendant company on the life of said Reynolds in the amount of One Hundred Thousand Dollars ($100,000.00). The beneficiary was the Atlas Lumber and Door Company, Inc., represented herein by the plaintiff-receiver, William A. Thorne.

Included with the application was an aviation supplement covering the life of Reynolds in the event he died as the result of an airplane crash.

After the application was filled out and signed, Knoop received a check made out by Reynolds to defendant's order in the amount of Eighty-Six and 56/100 Dollars ($86.56), representing the value of the first month's premium under the policy applied for. Said check was subsequently cashed on December 17, 1964, and the proceeds thereof were placed in the "Suspense Account" of the South Bend agency of defendant company.

As a part of the same December 10th transaction, agent Knoop gave Reynolds a form entitled "Binding Receipt for payment to apply on first premium". In pertinent part, said Receipt provided:

> (the insurance) shall be effective from the date of medical examination (being the last examination if more than one is required by the Company), subject to the provisions of the form of policy applied for, provided the Company shall be satisfied that on said date the applicant was insurable as a standard risk in accordance with its rules and practices for said amount on said plan.

7. Reynolds left South Bend, Indiana, by plane on December 23rd, 1964, for a vacation trip to Florida. That plane crashed in Florida, causing the death of Reynolds on January 3, 1965.

[432] 8. On January 8th, 1965, an agent of defendant forwarded a check in the amount of Three Hundred Twenty-Eight and 1/100 Dollars ($328.01) to Atlas Lumber and Door Company, Inc., made payable to that company. Accompanying said check was a letter stating that, "We are returning herewith payments submitted with applications for insurance on the life of Robert G. Reynolds since no policies were issued and no insurance became

effective". The uncashed check and the letter remained in the hands of the receiver herein until January 12th, 1966, at which time the check was deposited by him in the Clerk's office of this Court. At all times there was sufficient money in defendant's account to honor the check. No objection was ever made as to inadequate tender of the premium amount.

9. No written policy of life insurance ever was issued by defendant company to Reynolds.

10. The defendant company has not paid the proceeds of any life insurance to the plaintiff or to any other person on account of the death of Reynolds.

11. Other relevant events and facts surrounding the December 10th, 1964, transaction are found to be as follows:

A. On September 30, 1964, Reynolds applied for a $33,000 decreasing term mortgage insurance policy. A "binding receipt" was issued. A medical examination was set up for Reynolds by an agent for two or three days hence. That appointment was not kept. On October 30th, 1964, and after Reynolds had missed several appointments previously scheduled, he took the examination for the $33,000 policy only after Knoop and Charles Pease, an agent for an independent insurance brokerage company, picked up Reynolds at his office [433] and transported him by automobile to the doctor's office. On one occasion previous to October 30th, Reynolds had been told by Knoop that he had no insurance in full force until an examination was taken. Reynolds' reply was that he was aware of that fact and that he would get in for the physical.

Because of information obtained partially as a result of the October 30th examination and partially from other sources, Reynolds was requested to resubmit to another examination for which it was important that a current home office specimen with

specific gravity be obtained. This was to be sent to defendant's home office in order that doctors there might correlate Reynolds' medical condition with the medical requirements for the $33,000 policy. Several appointments were set up for such examination at Reynolds' convenience, and he was repeatedly informed of the necessity that it be taken. Although Reynolds always maintained that he had no objection to taking this or any other examination, all such appointments were broken, with various excuses for so doing being offered. As of January 3rd, 1965, a second medical examination for the $33,000 policy had not been taken, although Reynolds told Knoop on December 10th that it had been.

B. During the period between October 30th, 1964, and December 10th, 1964, Aetna, as the result of information received from various sources, had become aware that Reynolds' case was "special class, at best". Aetna knew, prior to December 10th, 1964, that Reynolds was a substandard risk, at best.

C. On December 10th, 1964, at the time the application for the $100,000 policy was made, Reynolds [434] was informed that a complete medical examination (which would also have sufficed for the September 30th application which was still pending) was necessary and that an electrocardiogram and chest x-rays were required for this policy. It would not have been issued without such information. The examination was set up in the presence and with the agreement of Reynolds for the following day. The appointment was not kept. Although Reynolds was again thereafter urged to keep such an appointment, none had been at the date of his death.

D. At the same December 10th meeting, Reynolds was informed that he would be, at best, a substandard

risk. He was again told that coverage would not be in full force until such time as the necessary medical requirements were met.

E. Reynolds indicated upon the application form for the $100,000 policy that although insurance with "Great West" was then in force, the September 30th application for $33,000 mortgage insurance was still "pending".

12. Robert G. Reynolds was a man of considerable business acumen and experience, acquired as the result of extensive executive responsibilities.

13. Defendant did not at any time or in any way prior to January 8th, 1965, indicate that it thought that a $100,000 policy of life insurance on the life of Reynolds was in full force and effect. It consistently required that the conditions as to the taking of the medical examination and as to insurability be met.

[435] 14. As of January 8th, 1965, Aetna had made no determination as to whether or not Reynolds was insurable under any of its conditions, including insurability as a substandard risk, nor could it have made such a determination, since the medical evidence available to it at that time was not sufficient to enable it to make such a determination. The reason for the lack of such evidence was Reynolds' own refusal to cooperate in meeting the appointments for medical examinations set up for him.

15. It is not possible for the Court to determine whether or not Reynolds met minimum standards of insurability for the period December 10, 1964, to January 3, 1965.

16. There were no material omissions made in Reynolds' December 10th, 1964, application with respect to the prior condition of his health.

II.

Conclusions of Law.

1. The Court has jurisdiction over the parties and subject matter pursuant to 28 U. S. C., Section 1332.

2. The plaintiff, William A. Thorne, is the proper party to bring this action.

3. The Atlas Lumber and Door Company, Inc., is the proper beneficiary of any proceeds which might issue under the life insurance policy in issue here.

4. Robert G. Reynolds was not guilty of any fraud or misrepresentation in connection with information supplied by him on the December 10th, 1964, application.

5. Aetna Life Insurance Company was not guilty of any fraud or misrepresentation in connection with the issuance on December 10th, 1964, of the "binding receipt" for the life insurance policy here in issue.

6. Aetna Life Insurance Company did not waive any rights accruing to it by retaining the benefit of the first month's premium tendered to it in connection with the December 10th, 1964, application. A sufficient tender back of such money was made.

7. There was at no time in full force and effect any contract, whether by operation of waiver of conditions, construction of mutual intent, or by application of a rule of unconscionability, by which defendant, Aetna Life Insurance Company, was obligated to pay the beneficiary, Atlas Lumber and Door Company, Inc., any proceeds from a life insurance policy on account of the death of Robert G. Reynolds.

8. The defendant is not liable to the plaintiff.

Memorandum.

In connection with the Court's seventh con sion of law, we would add the following comment:

The facts underlying that conclusion are not in essential conflict. The language of the so-called binding receipt which forms the nexus of this dispute is clear; Aetna, on its part, agrees to become bound upon the fulfillment of conditions precedent requiring the taking of (the last) medical examination and satisfaction that upon said date the applicant was insurable as a standard risk. It knew, of course, that Reynolds was a "substandard risk, at best", and accordingly waived its right to insist that the applicant be a standard risk. On his part, Reynolds knew that specific medical information was needed in order to evaluate the condition of his health and thence to act on both the $33,000 and $100,000 applications. Through no fault of their own, the Aetna agents were unable to acquire medical evidence sufficient to ascertain whether or not Reynolds would have been insurable even as the least insurable type of substandard risk. As stated, the fault lies with Reynolds for not having kept appointments which would have provided such information.

On these facts, the controlling Indiana case is *Western & Southern Life Ins. Co.* v. *Vale*, 213 Ind. 601, 12 N. E. 2d 350 (1938). In Vale, plaintiff, a fifty-five year old illiterate coal miner, applied for a policy of industrial insurance. The receipt given him, after payment of a first month's premium, stated:

> "Provided the insured be in sound health and over six months of age on the date of said application, the company's liability under such policy, if and as issued, shall commence as of the date of said application."

The evidence showed that plaintiff was reasonably insurable and that a company agent had represented to him that

the insurance would be in effect from the date the receipt for the first month's premium was issued. In holding for plaintiff, the court not only examined the parties' understanding of the transaction in terms of the particular facts of the case, but went further in an effort to ascertain the fair and reasonable understanding that "an applicant for industrial insurance or any reasonable person" would have when issued a conditionally binding receipt upon payment of a premium.

In determining the actual intent of the two parties involved, Vale found significant the fact not only that plaintiff had represented that he was in good health but that this fact was true, the manager of defendant's industrial insurance department testifying that plaintiff was a first-class risk. In addition, it had been represented that insurance would be in effect from the time the premium was paid.

When related to the terms of the conditional receipt there in issue, this evidence probably would have been enough for a finding in favor of plaintiff, but the court went on to make the following comments upon situations involving the payment of premiums and issuance of receipts therefor. It said:

> "It would be unconscionable to permit an insurance company, issuing such a receipt, and receiving a premium from an applicant, part of which was to pay for protection under its policy from the date of the application to the date of acceptance, to say that it had not bound itself to give anything whatever for that portion of the premium, that it deliberately intended to accept the premium for that period, but that it never intended to, and that it had not insured the applicant for that period . . . An applicant for industrial insurance, or any reasonable person, understanding that he was insured but qualifiedly or conditionally, would look to the field covered by the company's inquiries for the material out of which the qualification

or condition would arise, and would assume that if the representations he had made, and upon which the company had been willing to become tentatively liable, were true, the company was bound. . . . It cannot be assumed that the applicant knowingly and intentionally paid his money to the company without any consideration, nor can it be assumed, in fairness to the company, that it intended to take the applicant's money without any consideration, and with the intention that he should not be insured upon any conditions for the period between the signing of the application and its acceptance and approval. Since no other reasonable construction is suggested, the agreement must be construed as intending that he be insured for the period if reasonably insurable. That is undobutedly what the applicant understood and believed he was agreeing to., It would be unconscionable to permit the company to assert that there was a meeting of the minds upon any other basis." (at 354-5.)

In comparing the facts of Vale with the facts in the case at bar, the first obvious consideration is that the applicant here, Reynolds, was not in any way misled. He knew that a medical examination was necessary in order to provide defendant company with information sufficient to evaluate the application for life insurance. There is not much more Aetna's agents could have done in attempting to obtain Reynolds' cooperation in this regard. Thus, the correlation between the conditions prescribed by the binding receipt and Reynolds' own understanding of them was great. He knew at all times what was supposed to be done. On this issue, the case upon which plaintiff here relies, *Prudential Insur. Co. of Amer.* v. *Lamme*, ... Nev. ....., 425 P. 2d 345 (1967) is distinguishable, for Lamme specifically found that the conditions contained in the binding receipt could not be understood by the ordinary applicant, absent an explanation of their meaning.

The remaining question raised by Vale in the context of

the understanding of the reasonable applicant, then, is whether or not defendant company here should be allowed to insist on the taking of a medical examination (or, "the last one if more than one is required") as a condition precedent to recovery. A corollary question is whether or not the company's satisfaction as to evidence of insurability is operative as a condition precedent.[1]

We think that both of these questions should be answered in the negative. In addition to Indiana's long-standing policies against forfeitures,[2] favoring one who stands in an inferior bargaining position,[3] and construing a printed form most strongly against the one who prepared it,[4] Vale evidences a strong determination to give an insurance applicant his quid pro quo. If, as the testimony in this case indicates, it is the insurance company's purpose, by securing the payment of a premium, to attempt to minimize the chances of an applicant's changing his mind or applying to another company for insurance during the time his application is pending, then such a person is entitled to protection during that time. Especially is this true when it is seen that the ultimate purpose of securing the payment of a first month's premium by issuing a "binding receipt", as understood by both the applicant and the company, is to provide coverage in the event that the applicant is found to be insurable in accordance with certain objective standards of the company. Such fact is em-

1. We construe this condition as requiring only that which would satisfy a reasonable man in the company's position. Restatement of Contracts sec. 265 (1932); 5 Williston on Contracts secs. 675A and 675B (3rd ed. 1961).

2. *Franklin Life Insur. Co.* v. *Wallace*, 93 Ind. 7, ... N. E. ..... (1883).

3. *Curtis* v. *Corya*, 117 Ind. App. 244, 69 N. E. 2d 742 (App. Div. 1946).

4. *Western & Southern Life Ins. Co.* v. *Vale, supra.*

phasized in the Aetna Life Career Course, a booklet designed for the use of Aetna agents, which states:

> "If the applicant pays the initial premiums at the time he applies for the insurance and is given a binding receipt, he has made the Company an offer as of the payment date. *The policy is in force as of the premium payment date, provided the applicant is an acceptable risk on the date he makes the payment.*" (Emphasis supplied.)

Once it is determined that the applicant is an acceptable risk, the usual practice is to back-date the policy and make it effective as of the date on which the conditional receipt was issued. Regardless, then, of whether or not any examination is ever taken, if it can be shown that the applicant was insurable, the company should not be heard to say that the failure to take a medical examination (or, consequently, the failure to provide proof of insurability) bars recovery. Such a position would not only defeat the very object for which the parties entered into the conditional relations, but would be, in the words of Vale, "to disclaim liability for some arbitrary reason of its own choosing".

We think that to find that insurance is in full force and effect from the time the receipt is issued and the premium paid, if the applicant is found to be insurable in connection with objective company standards, is the only result which does substantial justice both to the applicant and to the company.[5] In addition, we would note

5. Similar results have been reached in a number of well-reasoned cases generally following the principles announced in *Vale*. *See, e.g., New England Mut. Life Ins. Co. of Boston* v. *Hinkle*, 248 F. 2d 879 (8th Cir. 1957), *writ of cert. dismissed*, 358 U. S. 65 (1958); *Wright* v. *Pilot Life Ins. Co.*, 379 F. 2d 409 (4th Cir. 1967); *Liberty Nat'l. Life Ins. Co.* v. *Hamilton*, 237 F. 2d 235 (6th Cir. 1956); *Gaunt* v. *John Hancock Mut. Life Ins. Co.*, 160 F. 2d 599 (2d Cir. 1947); *Cliborn* v. *Lincoln Nat'l. Life Ins. Co.*,

that such a result has the additional advantage of fixing a definite time when the policy does or does not take effect, rather than having the insurance company act as the final arbiter in this regard by virtue of its ability to set the date of the first medical examination at will, and then to require such additional examinations as may be "necessary".

When this test is applied to the facts in the case at bar, it should be noticed that the question becomes *not* whether the insurance company did make, or could have made a determination as to insurability (compare the Court's fourteenth finding of fact), but rather whether or not the fact-finder, based on *all* medical evidence adduced at the trial, can make such a determination. Since the Court in this case has before it only that information which Aetna had available to it, we have found that the question of whether or not Reynolds came up to minimum standards of insurability for the period beginning December 10th, 1964, is, as it was for Aetna, incapable of determination, since the medical evidence necessary for making such a finding is wholly lacking due to the failure of Reynolds (and, therefore, of plaintiff herein) to provide the means necessary for obtaining it.

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332 F. 2d 645 (10th Cir. 1964); *Simpson* v. *Prudential Ins. Co. of Amer.*, 227 Md. 393, 177 A. 2d 417 (1962); *Morgan* v. *State Farm Life Ins. Co.*, 240 Or. 113, 400 P. 2d 223 (1965); *Stronsz* v. *Equitable Life Ass. Soc. of the United States*, 324 Pa. 97, 187 A. 403 (1936); *McAvoy Vitrified Brick Co.* v. *North Amer. Life Ass. Co.*, 395 Pa. 75, 149 A. 2d 42 (1959); *cf. Steelnack* v. *Knights Life Ins. Co. of Amer.*, 423 Pa. 205, 223 A. 2d 734 (1966). *See also Allen* v. *Metropolitan Life Ins. Co.*, 83 N. J. Super. 223, 199 A. 2d 254 (Super. Ct., App. Div. 1964), *rev'd.*, 44 N. J. 294, 208 A. 2d 638 (1965); *United Founders Life Ins. Co.* v. *Carey*, ... Tex. ....., 347 S. W. 2d 295 (Ct. of Civil Appeals 1961), *rev'd.*, ... Tex. ....., 363 S. W. 2d 236 (1962).

In the
United States Court of Appeals
For the Seventh Circuit

No. 17050 SEPTEMBER TERM 1968 — JANUARY SESSION 1969

WILLIAM A. THORNE, Receiver, Atlas Lumber & Door Co., *Plaintiff-Appellant*,

v.

AETNA LIFE INSURANCE COMPANY, *Defendant-Appellee*.

Appeal from the United States District Court for the Northern District of Indiana, South Bend Division.

February 24, 1969

Before DUFFY, *Senior Circuit Judge*, SWYGERT and CUMMINGS, *Circuit Judges*.

DUFFY, *Senior Circuit Judge*. This is a suit by the Receiver of Atlas Lumber & Door Company (Atlas) to recover $100,000 under a contract of interim insurance. The facts are largely stipulated.

On December 10, 1964, Robert G. Reynolds, the President of Atlas, made an application to Aetna Life Insurance Company (Aetna) for insurance on his life in the sum of $100,000.00 payable to the corporation. He paid one month's premium of $86.56. Reynolds received a receipt which used the words "Binding receipt" and stated it was on account of the first premium on the life of Robert Glenn Reynolds.

The receipt further provided that the insurance "shall be effective from the date of medical examination (being

the last examination if more than one is required by the Company) . . . provided the Company shall be satisfied that on said date the applicant was insurable as a standard risk in accordance with its rules and practices for said amount on said plan."

Under the heading "Notice re Binding Receipt" appears "This is a temporary receipt only. If the insurance is issued, a regular receipt signed by an executive officer of the Company and countersigned by the agent will accompany the policy."

Included in the application for insurance was an aviation supplement covering the life of Reynolds in the event he died in an airplane crash.

On September 30, 1964, Reynolds had applied for a $33,000.00 decreasing term insurance on which a similar "binding receipt" was issued. On October 30, 1964, Reynolds took an examination for that policy. He was requested to re-submit to another examination but he never did so. The Company's records show that Reynolds' case was "a special class at best," and Reynolds was regarded as a substandard risk. Reynolds was notified of this fact.

Without taking the physical examination as required by the insurance company, Reynolds left South Bend, Indiana, by plane on December 23, 1964, for a vacation trip to Florida. The plane crashed and Reynolds died on January 3, 1965.

The District Court found, and there is credible evidence to sustain the finding, that the Company's agent told Reynolds at least four times that he had no insurance coverage until he took his physical examination and that Reynolds understood this.

The complaint charged Aetna with fraud and misrepresentation but the trial court concluded that the evidence did not sustain such a charge. We agree!

The District Court found that "Because of information obtained partially as a result of the October 30th examination (on the application for the $33,000 policy) and partially from other sources, Reynolds was requested

to re-submit to another examination for which it was important that a current home office specimen with specific gravity be obtained. . . . Several appointments were set up for such examination at Reynolds' convenience, and he was repeatedly informed of the necessity that it be taken . . . all such appointments were broken, various excuses for so doing being offered."

As of January 3, 1965, Aetna had not made any determination as to whether or not Reynolds was insurable under any of its conditions. The trial court found that Aetna could not have made such determination since the necessary evidence was not available, and that the reason for such lack of evidence was Reynolds' refusal to cooperate by meeting the appointments for medical examinations which had been set up for him.

This case is to be decided under Indiana law and therefore requires an analysis of *Western & Southern Life Insurance Co.* v. *Vale,* 213 Ind. 601, 12 N.E. 2d 350. In that case, the policy did not contemplate a medical examination but rather relied upon representations made by the applicant in the written form to the effect that he was in sound health. The applicant paid a sum with the submission of the application and was issued a receipt which stated: "Provided the insured be in sound health . . . the company's liability under such policy, if and as issued, shall commence as of the date of said application."

Vale was told that his policy was in effect from the date of the receipt. The Indiana court was obviously concerned that the insurance company could, in case of death before notification of acceptance, simply reject the application. This would be unconscionable and therefore they construed the agreement as providing insurance if the applicant was reasonably insurable at the time of application.

Here, the "binding receipt" explicitly stated that the policy was not to be effective until the examination was had. Appellant argues that since he paid a sum and was given a "binding receipt," Indiana law requires that he be given coverage for the interim. We do not agree. Aetna was not entitled to arbitrarily reject the policy.

They were bound in the sense that if Reynolds had met their medical standards, objectively applied, he would have been entitled to insurance. The appellee could not have arbitrarily decided not to issue the policy after Reynolds had taken an examination even if he had died immediately thereafter, provided he had met their standard. The *Vale* case does not preclude an insurance company from refusing to begin coverage under a $100,000 policy until they are in a position to evaluate the risk. Reynolds was in no way misled about this requirement.

We therefore hold that the District Court was correct in concluding that there was at no time in effect any contract of insurance. In a memorandum accompanying that conclusion, the Court indicated that in its judgment it was open to the plaintiff to show that Reynolds had met the appellee's medical standards, even though he had never taken the required medical examination. This would, in effect, permit a person who had paid a sum to the insurance company and had been issued a "binding receipt," but who died before taking a medical examination, to demonstrate by other evidence that he was insurable.

The Court apparently was of the view that *Vale* required this result and so held despite the explicit provisions of the receipt delaying effectiveness until "the [illegible] medical examination." In the instant case, it is of no significance since Reynolds, by his failure to take the examination needed, made it impossible to determine whether he was insurable. We therefore decline to decide whether Indiana law requires that a similarly situated plaintiff be permitted to show that the deceased was insurable even though he did not take a medical examination. It is enough to say that here there was no contract since Reynolds did not have the medical examination needed to make a judgment as to his insurability.

The judgment of the District Court is

AFFIRMED.

A true Copy:
Teste:

.....
Clerk of the United States Court of Appeals for the [illegible] Circuit.

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IN THE

Supreme Court of the United States

OCTOBER TERM [redacted] 1969

[redacted] 193

WILLIAM A. THORNE, Receiver,
Atlas Lumber & Door Co.,

Petitioner,

vs.

AETNA LIFE INSURANCE COMPANY,

Respondant.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit.

BRIEF FOR THE RESPONDANT IN OPPOSITION

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BRIEF FOR THE RESPONDANT IN OPPOSITION

QUESTIONS PRESENTED FOR REVIEW

Neither of the questions stated in the Petitioner's petition are properly presented for review on the record and facts in this case.

The binding receipt referred to in Petitioner's first stated question read in pertinent part:

> "The insurance . . . shall be effective from the date of medical examination (being the last examination if more than one is required by the Company)."

Reynolds was told at the time that the binding receipt was given him that he would have no coverage until such time as he had taken a second complete medical examination, an electrocardiogram and a chest x-ray which were required for the policy. Further the Company consistently required that the conditions as to the taking of these medical examinations and as to insurability be met. (Findings of Fact of the Trial Court No. 6, 11 and 13.)

The record in this case does not present the second question as worded in the Petitioner's petition for writ of certiorari. The Company did not ". . . have knowledge of all of the facts . . ." because the medical evidence available to it was not sufficient to enable it to make a determination. The reason for the lack of the evidence was Reynolds own refusal to cooperate in meeting the appointments for medical examinations set up for him. The Company had consistently required that the conditions as to the taking of the medical examination and as to insurability be met. (Findings of Fact of the Trial Court No. 13 and 14).

CONCISE STATEMENT OF THE CASE

The Petitioner's statement omits many of the important facts of the case. The correct statement of the facts of the case is contained in the Trial Court's Findings of Fact No. 6 through No. 14:

> 6. On December 10, 1964, in the presence of agent Knoop, Reynolds filled out and signed an application for a policy of life insurance with defendant company on the life of said Reynolds in the amount of One Hundred Thousand Dollars ($100,000.00). The beneficiary was the Atlas Lumber and Door Company, Inc., represented herein by the plaintiff-receiver, William A. Thorne.
>
> Included with the application was an aviation supplement covering the life of Reynolds in the event he died as a the result of an airplane crash.

After the application was filled out and signed, Knoop received a check made out by Reynolds to defendant's order in the amount of Eighty-Six and 56/100 Dollars ($86.56), representing the value of the first month's premium under the policy applied for. Said check was subsequently cashed on December 17, 1964, and the proceeds thereof were placed in the "Suspense Account" of the South Bend agency of defendant company.

As a part of the same December 10th transaction, agent Knoop gave Reynolds a form entitled "Binding Receipt for payment to apply on first premium". In pertinent part, said Receipt provided:

> (the insurance) shall be effective from the date of medical examination (being the last examination if more than one is required by the Company), subject to the provisions of the form of policy applied for, provided the Company shall be satisfied that on said date the applicant was insurable as a standard risk in accordance with its rules and practices for said amount on said plan.

7. Reynolds left South Bend, Indiana, by plane on December 23rd, 1964, for a vacation trip to Florida. That plane crashed in Florida, causing the death of Reynolds on January 3rd, 1965.

8. On January 8th, 1965, an agent of defendant forwarded a check in the amount of Three Hundred Twenty-Eight and 1/100 Dollars ($328.01) to Atlas Lumber and Door Company, Inc., made payable to that company. Accompanying said check was a letter stating that, "We are returning herewith payments submitted with applications for insurance on the life of Robert G. Reynolds since no policies were issued and no insurance became effective". The uncashed check and the letter remained in the hands of the receiver herein until January 12th, 1966, at which time the check was deposited by him in the Clerk's office of this Court. At all times there was sufficient money in defendant's account to honor the check. No objection was ever made as to inadequate tender of the premium amount.

9. No written policy of life insurance ever was issued by defendant company to Reynolds.

10. The defendant company has not paid the proceeds of any life insurance to the plaintiff or to any other person on account of the death of Reynolds.

11. Other relevant events and facts surrounding the December 10th, 1964, transaction are found to be as follows:

A. On September 30, 1964, Reynolds applied for a $33,000 decreasing term mortgage insurance policy. A "binding receipt" was issued. A medical examination was set up for Reynolds by an agent for two or three days hence. That appointment was not kept. On October 30th, 1964, and after Reynolds had missed several appointments previously scheduled, he took the examination for the $33,000 policy only after Knoop and Charles Pease, an agent for an independent insurance brokerage company, picked up Reynolds at his office and transported him by automobile to the doctor's office. On one occasion previous to October 30th, Reynolds had been told by Knoop that he had no insurance in full force until an examination was taken. Reynolds' reply was that he was aware of that fact and that he would get in for the physical.

Because of information obtained partially as a result of the October 30th examination and partially from other sources, Reynolds was requested to resubmit to another examination for which it was important that a current home office specimen with specific gravity be obtained. This was to be sent to defendant's home office in order that doctors there might correlate Reynolds' medical condition with the medical requirements for the $33,000 policy. Several appointments were set up for such examination at Reynolds' convenience, and he was repeatedly informed of the necessity that it be taken. Although Reynolds always maintained that he had no objection to taking this or any other examination, all such appointments were broken, with various excuses for so doing being offered. As of January 3rd, 1965, a second medical examination for the $33,000 policy had not been taken, although Reynolds told Knoop on December 10th that it had been.

B. During the period between October 30th, 1964, and December 10th, 1964, Aetna, as the result of information received from various sources, had become aware that Reynolds' case was "special class, at best". Aetna knew, prior to December 10th, 1964, that Reynolds was a substandard risk, at best.

C. On December 10th, 1964, at the time the application for the $100,000 policy was made, Reynolds was informed that a complete medical examination (which would also have sufficed for the September 30th application which was still pending) was necessary and that an electrocardiogram and chest x-rays were required for this policy. It would not have been issued without such information. The examination was set up in the presence and with the agreement of Reynolds for the following day. The appointment was not kept. Although Reynolds was again thereafter urged to keep such an appointment, none had been at the date of his death.

D. At the same December 10th meeting, Reynolds was informed that he would be, at best, a substandard risk. He was again told that coverage would not be in full force until such as the necessary medical requirements were met.

E. Reynolds indicated upon the application for the $100,000 policy that although insurance with "Great West" was then in force, the September 30th application for $33,000 mortgage insurance was still "pending".

12. Robert G. Reynolds was a man of considerable business acumen and experience, acquired as the result of extensive executive responsibilities.

13. Defendant did not at any time or in any way prior to January 8th, 1965, indicate that it thought that a $100,000 policy of life insurance on the life of Reynolds was in full force and effect. It consistently required that the conditions as to the taking of the medical examination and as to insurability be met.

14. As of January 8th, 1965, Aetna had made no determination as to whether or not Reynolds was insurable under any of its conditions, including insurability as a substandard risk, nor could it have made such a determination, since the medical evidence available to it at that time was not sufficient to enable it to make such a determination. The reason for the lack of such evidence was Reynolds' own refusal to cooperate in meeting the appointments for medical examinations set up for him.

BASIS FOR JURISDICTION OF THIS COURT

There is no basis for the jurisdiction of this Court.

The alleged basis for jurisdiction of this Court set forth in paragraph 1 at page 6 of the Petitioner's Petition is accomplished by extracting certain limited language from an Indiana case decided under an entirely different factual situation, and most particularly an entirely different binding receipt. The comparison of the facts of the *Vale* case with the facts of the instant case shows:

Vale case	*Reynolds case*
a. The receipt read: "Provided the insured be in sound health and over six months of age on the date of said application, the Company's liability under such policy, if and as issued, shall commence as of the date of said application."	a. The receipt read: "Insurance . . . shall be effective from the date of medical examination (being the last examination if more than one is required by the Company); . . . provided the Company shall be satisfied that on said date the applicant was insurable as a standard risk in accordance with its rules and practices for said amount on said plan."
b. Vale was a coalminer who could not read.	b. Reynolds was the president of two corporations doing over one million dollars a year business.

c. The agent told Vale that his insurance was in effect from the date of the receipt.	c. The agent told Reynolds that he had no insurance coverage until he completed the necessary medical examinations.
d. Vale was applying for an industrial policy which required no physical test for submission to the home office medical advisors.	d. Reynolds was applying for $100,000 of life insurance and required both a complete physical examination, a chest x-ray, an electrocardiogram, and home office specimen for submission to the Company's medical advisors for analysis.
e. Vale took the only medical examination required of him.	e. Reynolds did not take the physical examination nor did he submit any of the medical requirements.
f. There was no question of Vale's insurability as a standard risk.	f. Reynolds had consulted at least two physicians within the previous year and one-half for conditions and symptoms which could be extremely serious.

The same observation must be made as to paragraph 2 of the Petitioner's Petition alleging a basis for jurisdiction of this Court, namely that the Court in the instant case was dealing with an entirely different factual situation, and most particularly with an entirely different receipt than was being discussed by the Indiana Supreme Court in the case of *Western & Southern Life Ins. Co. v. Vale*, 213 Ind. 601; 12 N.E.2d 350 (1937). In fact the *Vale* case specifically comments on the fact that medical examinations and tests were not required to be submitted to the home office in that case. 12 N.E.2d at 355.

Paragraph 3 which the Petitioner sets out as his basis for jurisdiction of this Court has no basis in the record. The attempt to invoke the jurisdiction of this Court is undertaken in

this third paragraph by including the assertion: ". . . with its previous knowledge of all the facts when it issued its Binding Receipt." This is actually incorrect. Aetna had made no determination as to whether or not Reynolds was insurable, nor could it have made such a determination since the medical evidence available to it was not sufficient for this purpose. The reason that Aetna did not have the evidence to make the determination was Reynolds own refusal to cooperate in meeting the appointments for medical examinations set up for him. The Company at all times had consistently required that the conditions as to the taking of the medical examination and as to insurability be met. (Findings of Fact of the Trial Court, No. 13 and 14).

ARGUMENT

The allegations which are set forth as the basis for the jurisdiction of this Court are not correct on the record. The Seventh Circuit Court of Appeals in its decision *William A. Thorne, Receiver vs. Aetna Life Ins. Co.*, 407 F.2d 809 (1969) properly distinguished the facts of the instant case and those of the *Vale* case. Its decision and conclusion are correct.

The rule of law in Indiana as set out in the decision of *Prudential Ins. Co. of America vs. Lancaster*, 219 N.E.2d 607 (Ind. App. 1966) is stated:

> "The well established rule in Indiana is that our Courts can only enforce the terms of a contract as agreed upon, and have no authority to make a new or different contract."

With the express findings of fact made by the Trial Court that Aetna did not have the information necessary to make a proper determination in regard to Reynolds' insurability, for the reason that Reynolds had failed to cooperate in meeting the appointments for medical examinations set up for him, coupled

with the Court's Finding of Fact that the Company had consistently required that the conditions as to the taking of the medical examinations and as to insurability be met, (Court's Findings of Fact No. 13 and 14), there was no question of waiver to be decided by the Court of Appeals.

To constitute a "waiver" under Indiana law there must be an intentional relinquishment of a right which ordinarily must be predicated on full knowledge of all the facts. Where the Company expressly and clearly notifies the other contracting party in advance of its insistence upon the terms of the contractural agreement, there can be no waiver. *State Farm Mutual Automobile Ins. Co. vs. Phillips,* 210 Ind. 561, 2 N.E.2d 989 (1936).

CONCLUSION

The Petition for Writ of Certiorari asserts as its basis for the jurisdiction of this Court that the Court of Appeals had decided an important State question in a way that conflicts with applicable State law. The record shows that the Court of Appeals actually followed the applicable State law of Indiana.

The second ground for the jurisdiction of this Court is alleged to be the failure of the United States Court of Appeals to decide the question of waiver, inserting the premise . . . "with its previous knowledge of all the facts", an assertion which is squarely contrary to the record in this case.

The bases for the jurisdiction of this Court on Certiorari as set forth in the Petitioner's Petition for Writ of Certiorari do not exist on the record, and the petition should be denied.

Respectfully submitted,

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